Health Care & Dependent Care Reimbursement Accounts

ENROLLMENT APPLICATION

(Check One) ☐ Initial Enrollment ☐ Plan Year Enrollment ☐ Change

(Please Print)

Employee Name: _____ Social Security No. _____

Address: _____ Employee ID No. _____

_____ Pay Frequency: Wkly. ____Mthly.____

_____ Effective Date: _____

Health Care Reimbursement Account

I hereby authorize Fermilab to reduce my earnings for the plan year 20 ___ by $ _____ for deposit into my Health Care Reimbursement Account and to make this money available to me for the reimbursement of out-of-pocket health expenses. I UNDERSTAND THAT I WILL FORFEIT ANY UNUSED BALANCE IN MY ACCOUNT AT THE END OF THE PLAN YEAR. I ALSO UNDERSTAND THAT I CANNOT CHANGE MY PLAN PARTICIPATION UNLESS I HAVE A CHANGE IN FAMILY STATUS, AS DEFINED BY INTERNAL REVENUE CODE SECTION 125.

Signature _____ Date _____

Dependent Care Reimbursement Account

I hereby authorize Fermilab to reduce my earnings for the plan year 20 ___ by $ _____ for deposit into my Dependent Care Reimbursement Account and to make this money available to me for the reimbursement of out-of-pocket dependent care expenses. I UNDERSTAND THAT I WILL FORFEIT ANY UNUSED BALANCE IN MY ACCOUNT AT THE END OF THE PLAN YEAR. I ALSO UNDERSTAND THAT I CANNOT CHANGE MY PLAN PARTICIPATION UNLESS I HAVE A CHANGE IN FAMILY STATUS, AS DEFINED BY INTERNAL REVENUE CODE SECTION 125.

Signature _____ Date _____

NOTE: Salary reduction elections must be made in whole dollar amounts. These elections will be divided by the number of pay periods in the plan year 20 ___, and be credited to your Account or Accounts on a monthly basis. Your salary reduction is made on a pre-tax basis in accordance with the IRC Section 125 guidelines.

For Departmental Use Only

Health Care:	U-Bal. $ _____	D-Bal. $ _____	G-Bal. $ _____
Dependent Care:	U-Bal. $ _____	D-Bal. $ _____	G-Bal. $ _____